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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey conducted at your facility on October 5, 2010 through October 8, 2010, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 36 residents. The sample size was 10 sampled residents which included 1 closed record, and 2 unsampled residents. There were no complaints investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure assessments were completed for the use of lap buddyies for 3 of 10 sampled residents (Residents #4, #9, and #5).	F 221		12/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Findings include:

Resident #4

Resident #4 was admitted on 01/12/10 and readmitted on 2/2/10 with diagnoses including cerebral vascular accident, vascular dementia, paralysis agitans, chronic obstructive pulmonary disease and Parkinson's syndrome.

From 10/05/10 through 10/08/10, Resident #4 was observed in a wheelchair with a lap buddy in place.

The resident's legal representative signed a consent for a lap buddy to be used due to high fall risk and poor gait on 01/13/10. There was no physical restraint assessment completed for the use of the lap buddy.

On 8/4/10, the occupational therapy evaluation documented the evaluation was for "PT (physical therapy)/OT (occupational therapy) screen for safety." The Occupational Therapist (OT) documented the resident was observed in a standard wheelchair without foot pedals with optimal seating and positioning. The resident demonstrated a continued problem of attempting to arise to stand/ambulate and presented as a high fall risk with a recent fall on 08/04/10. The OT recommended alternative methods versus physical and mechanical restraint as physical restraint would contribute to increased anxiety. The alternative methods would include the use of a Merry Walker for a trial basis. The Merry Walker was not available and other alternative methods included increased supervision, distraction techniques, and walking program for

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increased stimulation.

On 8/4/10, the physician order documented lap buddy per family request.

The record lacked documented evidence the facility had completed a restraint assessment for the use of the lap buddy to ensure the lap buddy was the least restrictive device.

The record lacked documented evidence the facility obtained a signed consent for the use of the lap buddy from the resident's legal representative.

On 10/08/10 at 8:45 AM, Employee #2 revealed the resident had a lap buddy on admission to the facility. The lap buddy was then discontinued. The resident's family requested the lap buddy in August 2010. Employee #2 indicated a restraint assessment for the lap buddy ordered on 08/04/10 should have been done and a new consent for the lap buddy should have been obtained.

The facility did not have a policy regarding restraint assessment and reassessment for the Long Term Care Unit.

Resident #9

Resident #9 was admitted on 04/11/08 with diagnoses including Alzheimer's dementia, dementia without behavior disturbance, hypertension, and diabetes.

On 10/08/10 at 9:30 AM, the resident was observed in a wheelchair sitting on a pummel cushion with lap buddy in place.

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F 221	Continued From page 3 On 4/22/08, the occupational therapist completed a positioning evaluation with recommendations for active occupational therapy for optimal seating positioning twice a week for 2-3 weeks, attempted pummel cushion for safety. It was determined the pummel cushion was not appropriate and the resident continued attempts of unsafe standing and the pummel cushion caused an increased risk. The lap buddy was placed for safety. On 5/1/08, the occupational therapist note documented a follow-up with wheelchair positioning for the least restrictive device. An easy flip away tray was tried. It was determined the resident was lifting the tray. The occupational therapist determined the flip away tray was inappropriate and all options had been tried for the least restrictive device and the lap buddy should be continued for the resident's safety and to decrease the resident's fall risk. On 7/21/08, the occupational therapist note documented the lap tray was needed for optimal resident's positioning and safety. The resident fluctuated with level of alertness and daily monitoring was required. The occupational therapist recommended a lap tray for wheelchair positioning. On 8/21/08, the physician order documented to discontinue the lap tray, lap buddy and pummel cushion in wheelchair for proper positioning. On 8/21/08, the physical restraint assessment documented the resident had diagnoses of Alzheimer's dementia and transient ischemic attack. The type of restraint to be used was a lap buddy and pummel cushion in wheelchair for	F 221		

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proper positioning. The benefit would be proper body alignment. Occupational therapy evaluation was completed and it was determined the restraint was the least restrictive.

The resident's family signed the consent for a lap buddy to be used for increased safety and decreased fall risk on 11/13/08.

The assessment lacked documentation supporting the need for the lap buddy and pummel cushion in the wheelchair for proper positioning. Although the occupational therapist recommended a lap tray to be used, the record lacked documentation the use of the lap buddy and pummel cushion was reassessed for continued need.

On 10/08/10 in the morning, Employee #2 revealed there was no long term care policy regarding reassessing the resident for the continued need for a restraint device or for the least restrictive device available.

Resident #5

Resident #5 was admitted on 11/2/09 with diagnoses including mental disorder/advanced dementia, depression, anxiety, debility, hypertonic bladder, hypertension, constipation, and traumatic fracture.

From 10/05/10 through 10/08/10, Resident #5 was observed in a wheelchair with a lap buddy in place.

On 11/27/09, a physician wrote an order for a lap buddy to be used in the wheelchair due to a high risk of falls.

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F 221	Continued From page 5 The resident's legal representative signed a consent for a lap buddy to be used for safety from falling out of the wheelchair on 12/06/09. There was no physical restraint assessment completed for the use of the lap buddy. The record lacked documented evidence the facility had completed a restraint assessment for the use of the lap buddy to ensure the lap buddy was the least restrictive device. On 10/08/10 at 11:30 AM, Employee #2 provided copies of the initial physician's order and consent but no physical restraint assessment was found. Employee #2 revealed there was no long term care policy regarding reassessing the resident for the continued need for a restraint device or for the least restrictive device available.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care for residents in a manner and environment that enhanced their dignity and respect. Findings include: The facility's Resident Rights policy (undated) documented, "privacy will include: personal care,	F 241		12/30/10

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F 241	Continued From page 6 medical treatments, telephone use, visits, letters and meetings of family and resident groups." On 10/7/10, in the morning staff members entered occupied resident rooms 253 and 268 without knocking or announcing themselves before entering. On 10/7/10 at 1:15 PM, Employee #2 verbalized the facility expected staff to provide privacy for residents and staff should ask permission to take a blood pressure or give medications in the hallway. Employee #2 added it was not okay to take a resident's blood pressure in the middle of a meal. On 10/06/10 at 7:30 AM, a licensed nurse was observed taking a resident's blood pressure while the resident was eating breakfast.	F 241		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate services to a resident to prevent a decline in range of motion for 1 of 10 sampled residents (Resident #2).	F 318		

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Findings include:

Resident #2

Resident #2 was admitted on 3/13/10 with diagnoses including mental disorder/dementia, adult failure to thrive, debility, benign prostatic hypertrophy, restless leg syndrome, hypothyroidism, hypertension, hyperlipidemia, and dysphagia.

From 10/05/10 to 10/08/10, Resident #2 was observed self-propelling in a wheelchair displaying minimal leg/feet movement. The resident generally remained close to the rails and used arm strength primarily.

The initial MDS (minimum data set) dated 3/25/10 documented section G4.d.e. as limited range of motion on bilateral legs and feet with partial loss of voluntary movement.

A case conference note dated 6/11/10 indicated the resident's spouse was concerned about the resident receiving enough exercise to maintain flexibility and strength.

The quarterly MDS dated 6/25/10 documented section G4.d.e. as limited range of motion on bilateral legs and feet with partial loss of voluntary movement.

On 8/05/10, a physician ordered a physical therapy (PT) screen for strengthening.

On 8/11/10, Employee #4 performed a rehabilitation screen and indicated muscle atrophy, paralysis, reduced range of motion, and

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decreased strength in lower extremities in the recommendation for the nursing rehabilitation program. On 8/11/10, Employee #4 completed a restorative care program referral form but failed to sign the form.

The quarterly MDS dated 9/15/10 documented section G4.d.e. as limited range of motion on bilateral legs and feet with additional full loss of voluntary movement in comparison to 6/25/10.

Resident #2's file lacked documented evidence of participation in any therapy or restorative care program after 8/11/10.

According to the facility's restorative nursing coordinator policy, last revised on 11/07/95, the restorative nursing coordinator assisted in obtaining physicians' orders for participation in the program.

Resident #2's file lacked documented evidence of a physician's order for participation in the program.

On 10/05/10 at 2:45 PM, Employee #4 indicated she referred Resident #2 to the restorative care program, and the resident was difficult to work with.

On 10/05/10 at 2:50 PM, Employee #5 indicated she did not recall documenting anything about picking up the resident for restorative assistance, and the resident was resistant and hard to work with.

According to the facility's restorative aide policy, last revised on 11/07/95, the restorative aide was responsible for documenting restorative treatment

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F 318	Continued From page 9 given. On 10/05/10 in the afternoon, Employee #2 indicated restorative aides documented in the nursing notes. Resident #2's nursing notes failed to contain references to any therapy or restorative care program participation between 8/11/10 and 10/05/10.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure the resident's environment remained as free of accident hazards as was possible for 2 unsampled residents (Residents #11 and #12). Findings include: Resident #12 Resident # 12 was admitted to the facility on 7/7/10, with diagnoses including congestive heart failure, hypertension and chronic back pain. The medical record lacked a physician's order for	F 323		

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the medications including saline nasal spray, antacids and Cepacol lozenges.

The medical record lacked documentation the resident was assessed self administration and comprehensive care plan was completed.

On 10/5/10 during the facility tour, a bottle of saline nasal spray, antacids and a box of Cepacol lozenges were on the resident's night stand. Employee #3 verbalized she did not know the resident had medications at her bedside.

On 10/6/10 at 1:50 PM, a bottle of saline nasal spray, antacids and a box of Cepacol lozenges were on the resident's night stand.

On 10/7/10 at 8:00 AM, Employee #2 was shown the medications at Resident #12's bedside. Employee #2 verbalized "I have a problem with that." The employee verbalized the medications should not be at the resident's bedside.

On 10/7/10 at 10:00 AM, Employee #1 verbalized the unit had two residents who wandered around the facility and in and out of other residents' rooms. Employee #1 stated there was the potential they would put something in their mouth from another residents' rooms.

Resident #11

Resident #11 was admitted to the facility on 1/1/10, with diagnoses including baseline dementia.

The medical record contained a physician's order for hydrocortisone cream 1% as needed three

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F 323	Continued From page 11 times a day for itching. During the facility tour on 10/5/10, a tube of hydrocortisone cream 1% was on a shelf in the resident's room. Employee #3 verbalized she did not know the resident had medications at her bedside. On 10/6/10 at 1:45 PM, a tube of hydrocortisone cream 1% was observed on a shelf in the resident's room. On 10/7/10 at 10:40 AM, Employee #1 verbalized the medications should not be at the resident's bedside. The employee was not sure why the medication was at the resident's bedside. Employee #1 verbalized there was no physician's order, care plan or self administration assessment in the medical record for the hydrocortisone cream 1% at bedside. The facility's policy entitled Quality control/drug storage/monthly inspections (unclear date) documented, ".. Any drug found improperly stored, outdated, contaminated and /or visibly deteriorated shall be removed and replaced..."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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F 329	Continued From page 12 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review, the facility failed to ensure residents were assessed for the use of antipsychotics, consents for the use of antipsychotics were obtained, and failed to attempt a gradual dose reduction for 3 of 10 sampled residents (Residents #9, #6, and #2). Findings include: The Chemical Restraint Guidelines dated 05/28/02 documented the following: "...Antipsychotic Drugs (Thorazine, Sparine, Vesprin, Mellaril, Serentil, Tindal, Trilafon, Prolixin, Stelazine, Taractan, Navane, Haldol, Moban, Loxitane, Clozaril, Compazine, Risperdal, Zyprexa, Orap, Seroquel)... Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following 'specific conditions':	F 329		

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F 329	Continued From page 13 1. Schizophrenia 2. Schizo-affective disorder 3. Delusional disorder 4. Psychotic mood disorders (including mania and depression with psychotic features) 5. Acute psychotic episodes 6. Brief reactive psychosis 7. Schizophreniform disorder 8. Atypical psychosis 9. Tourette's disorder 10. Huntington's disease 11. Organic mental syndrome (now called delirium, dementia, and amnestic and other cognitive disorders with associated psychotic and/or agitated behaviors)... Behaviors must be: persistent, not caused by preventable reasons, which are causing the resident to present a danger to himself/herself or to others... Antipsychotics should not be used if one or more of the following is/are the only indication: Wandering, poor self care, restlessness, impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness, agitated behaviors which do not represent danger to the resident or others... Unless clinically contraindicated, residents must have gradual dose reductions of the antipsychotic drug twice a year... Clinically contraindicated means that a resident does not need to undergo a gradual dose reduction if: the resident has a 'specific condition listed in 1-10...and as a history of recurrence of psychotic symptoms which have been stabilized	F 329		

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with a maintenance dose without significant side effects he/she need not undergo a gradual dose reduction...

The resident has organic mental syndrome and has had a gradual dose reduction attempted twice in one year and that attempt resulted in the return of symptoms to the degree that a return to previous dose is necessary...

The resident's physician provides justification why the continued use of the drug and the dose of the drug is clinically appropriate a) diagnosis, description of symptoms; b) why the resident's behavioral symptom is thought to be a result of a dementia with associated psychosis and not the result of an unrecognized painful medical condition or psychosocial or environmental stressor; c) a description of the justification for the choice of a particular treatment; d) discussion of why the present dose is necessary to manage the symptoms of the resident..."

Resident #9

Resident #9 was admitted on 04/11/08 with diagnoses including Alzheimer's disease and dementia without behavior disturbance.

The Antipsychotic Diagnosis Form was not completed.

1. On 4/11/08, the chemical restraint assessment documented the medication ordered was Haldol. The resident's diagnosis was Alzheimer's dementia with the specific behaviors as restless, confused and anxious. The resident exhibited behaviors including being easily distracted, periods of altered awareness, restlessness,

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altered sleep pattern/insomnia, wandering, resists care, and hallucinations/delusions. The frequency of the behaviors was described as periodic and the behaviors were attributed to the resident's Alzheimer's dementia. The interventions used to alter the behaviors included redirection and medication.

On 4/15/08, a physician order documented to discontinue the as needed Haldol.

On 7/12/10, a physician order documented to discontinue the Risperidone and start Haldol 0.5 milligrams twice a day.

On 9/28/10, the social service assessment documented the resident was receiving Risperdal for restlessness, and was changed to Haldol due to insurance purposes. The resident exhibited restlessness, repetitive noises, moving her legs and wandering.

The record lacked documented evidence an assessment was completed for the use of Haldol and the justification for the use of Haldol. The record lacked documented evidence a consent for the use of Haldol was obtained from the resident's legal representative.

2. On 4/18/08, a physician order documented Risperdal 0.5 milligram daily.

On 4/20/08, a physician order documented to change the Risperdal to 0.5 milligrams twice a day.

On 11/13/08, the Consent to use Chemical/Physical Restraint form documented a verbal consent from the resident's legal

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representative for the use of Risperdal for Alzheimer's dementia.

The record lacked documented evidence of an assessment for the use of Risperdal and the justification for the use of Risperdal.

On 10/08/10 in the morning, Employee #2 indicated there was no assessment for the use of Haldol when the physician ordered the Haldol on 07/12/10. Employee #2 indicated there was no assessment for the use of the Risperdal.

Resident #2

Resident #2 was admitted on 3/13/10 with diagnoses including mental disorder/dementia, adult failure to thrive, debility, benign prostatic hypertrophy, restless leg syndrome, hypothyroidism, hypertension, hyperlipidemia, and dysphagia.

The Antipsychotic Diagnosis Form was not completed.

The Consent to use Chemical/Physical Restraint form, dated 4/27/10, documented a written consent from the resident's legal representative for the use of Risperdal for agitation.

Resident #2's file lacked a chemical restraint assessment.

The Physician Order dated 3/13/10, documented Risperdal 0.5 milligrams per gastrostomy tube every 12 hours daily. On 5/03/10, the order changed to Risperdal 0.5 milligrams by mouth every 12 hours daily. On 8/25/10, the order

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changed to Risperdal 0.5 milligrams by mouth every 8 hours daily to the present time.

Risperdal 0.5 milligrams daily remained on the medication administration record as of 10/08/10.

On 10/08/10 in the morning, Employee #2 indicated there was no assessment for the use of Risperdal.

Resident #6

Resident #6 was admitted on 3/03/09 with diagnoses including mental disorder, dementia, chronic airway obstruction, hypertension, chronic kidney disease, myocardial infarction, depression, hyperlipidemia, constipation, and stroke.

The Antipsychotic Diagnosis Form was not completed.

The Consent to use Chemical/Physical Restraint forms, dated 5/20-22/09, documented a written consent from the resident's legal representative for the use of Risperdal and Haldol.

On 5/18/09, a chemical restraint assessment was completed.

The Physician Order dated 1/01/10, documented Risperdal 1 milligram nightly. On 3/10/10, the order was changed to Risperdal 0.5 milligrams nightly and remained so, as of 10/08/10. The Physician Order, dated 1/01/10, documented Haldol 5 milligrams intramuscular every 6 hours as needed and remained so, as of 10/08/10.

According to the facility's computerized medication detail report covering 2/02/10 to

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F 329	Continued From page 18 10/06/10, Resident #6 received a 5 milligram injection of Haldol at 11:52 PM on 6/03/10. The target behavior was listed as restlessness. According to the aforementioned chemical restraint guidelines, "antipsychotics should not be used if one or more of the following is/are the only indication:...restlessness..." On 10/08/10 in the morning, Employee #2 indicated to look in the progress notes when asked for physician documentation regarding demonstrating continued need for anti-psychotics. The progress notes lacked documented evidence of a physician statement indicating the need for continued Risperdal and Haldol use as of 10/08/10. The facility's consultant pharmacist's medication regimen review lacked documented evidence a dose reduction was ever attempted for Risperdal between 3/10/10 and 10/08/10 and for Haldol between 1/01/10 and 10/08/10.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		

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F 431	Continued From page 19 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure medications were properly stored for 2 unsampled residents (Residents #11, #12). Findings include: Resident #12 Resident #12 was admitted to the facility on 7/7/10, with diagnoses including congestive heart failure, hypertension and chronic back pain. The medical record lacked a physician's order for the medications for saline nasal spray, antacids and Cepacol lozenges.	F 431		

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F 431	Continued From page 20 During the facility tour on 10/5/10, a bottle of saline nasal spray, antacids and a box of Cepacol lozenges were on the resident's night stand. Employee #3 verbalized she did not know the resident had medications at her bedside. On 10/6/10 at 1:50 PM, a bottle of saline nasal spray, antacids and a box of Cepacol lozenges were on the resident's night stand. On 10/7/10 at 8:00 AM, Employee #2 was shown the medications at Resident # 12's bedside. Employee #2 verbalized "I have a problem with that." The employee verbalized the medications should not be at the resident's bedside. Resident #11 Resident #11 was admitted to the facility on 1/1/10, with a diagnoses including baseline dementia. The medical record contained a physician's order for hydrocortisone cream 1% as needed three times a day for itching. During the facility tour on 10/5/10, a tube of hydrocortisone cream 1% was on a shelf in the resident's room. Employee #3 verbalized she did not know the resident had medications at her bedside. On 10/6/10 at 1:45 PM, a tube of hydrocortisone cream 1% wason a shelf in the resident's room. On 10/7/10 at 10:40 AM, Employee #1 verbalized the medications should not be at the resident's bedside. The employee was not sure why the	F 431		

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F 431	Continued From page 21 medication was at the resident's bedside. The facility's policy entitled Quality control/drug storage/monthly inspections (unclear date) documented, "... Any drug found improperly stored, outdated,contaminated and /or visibly deteriorated shall be removed and replaced..."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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F 441	Continued From page 22 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a safe and sanitary environment was maintained to prevent the control of infections. Findings include: On 10/5/10 at 4:25 PM, Employee #1 was observed calibrating the glucometer, and placing a test strip into the glucometer. The employee put on a pair of gloves and walked down the hallway through the dining room and to the patio outside. The employee proceeded to take a resident's blood sugar. After finishing the procedure, Employee #1 walked back into the facility, through the dining room to the nurse's station with gloves on and blood on the test strip still attached to the glucometer. Employee #1 entered a code into the glucometer and removed her gloves. The employee entered the medication room and prepared an insulin syringe for the resident. Employee #1 gathered the supplies for an insulin injection and put on a pair of gloves. The employee did not wash her hands before putting the gloves on or after removing her used	F 441		

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F 441	Continued From page 23 gloves. Employee #1 walked down the hallway into the dining room and administered the insulin to the resident. The employee returned to the nurse's station and disposed of the syringe, used alcohol wipe and removed her gloves. Employee #1 did not wash her hands after removing her gloves. Employee #1 walked over to the medication cart and signed out the medication that had been given. The facility's policy entitled Medical Equipment Cleaning dated 10/8/09, documented,"... the Glucometer should be cleaned with a germicidal disposal wipe every morning when the quality control is being done and between each resident: and as needed..." The facility's policy entitled Hand hygiene Program dated 10/13/2008, documented "...personnel shall wash their hands before applying and after removing gloves..." On 10/7/10 at 10:30 AM, Employee #1 verbalized the facility policy indicated to wash hands after gloves were removed. The employee verbalized it was not correct to walk through the hallway of the facility with gloves on or with a test strip containing blood.	F 441		